Haydn-Barlow Care Limited

Holmfield Nursing Home

Inspection report

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Warwickshire
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Tel: 02476345502

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
Holmfield Nursing Home is a care home, providing personal care, nursing and accommodation. There were 17 people with frailty due to older age living at the home at the time of the inspection.

What life is like for people using this service:
• People felt care staff were kind towards them and looked after them well. However, there were not enough staff. Planned for activities did not always take place because sufficient staff were not on shift to meet people's needs.
• Most people had individual plans of care, so staff had the information they needed to care for them. However, this was inconsistent and one person had no individual plan of care.
• Risks were not always identified, and risk management plans were not always in place.
• People's prescribed medicines were available, but medicines were not always managed safely which posed risks to people's health and wellbeing.
• Staff did not always have the necessary skills to meet people's needs.
• Staff employment files did not contain the information required to show the provider had undertaken required checks to ensure staff suitability.
• Care staff understood the need to gain people's consent before personal care was provided. However, the provider had not ensured staff consistently understood, and worked within, the requirements of the Mental Capacity Act 2005.
• Most staff completed self-guided training, however some told us they had not received training.
• People were supported to eat and drink adequately.
• Care staff, the cook and the housekeeper interacted positively with people, showing kindness and compassion.
• People and relatives were, overall, complimentary about staff and had no current complaints. However, some complaints had not been recorded.
• There was no managerial oversight of the home in the provider's, nominated individual's and home manager's absence. The lack of effective governance meant aspects of the quality and safety of the service were poor.
• The provider's quality assurance system did not ensure quality and safety. General décor and maintenance required repair. Some maintenance issues posed potential risks of cross infection because effective cleaning could not take place.

Following our inspection, we notified relevant stakeholders including the Local Authority and Local Clinical Commissioning Group (CCG) about the areas of concern we identified.

We reported that the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:
Regulation 9 Regulated Activities Regulations 2014 - Person centred care
Regulation 11 Regulated Activities Regulations 2014 – Need for consent

Regulation 12 Regulated Activities Regulations 2014 - Safe care and treatment
Regulation 17 Regulated Activities Regulations 2014 - Good governance
Regulation 18 Regulated Activities Regulations 2014 - Staffing

Rating at last inspection: The last report for Holmfield Nursing Home was published on 29 May 2018 and we gave an overall rating of Good.

Why we inspected: We received information of concern including infection prevention and control, and the administration of medicines, from a joint quality monitoring visit undertaken by the local Clinical Commissioning Group (CCG) and Local Authority (LA). The CCG and LA commission (purchase) packages of care on behalf of people. A relative contacted us about their complaint about the services provided.

Enforcement: Action provider needs to take (refer to end of report). Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up: On the day of our inspection visit, the provider, nominated individual and home manager were not available to be at the service. We gave detailed feedback to a senior person, by a telephone meeting, which took place with the nominated individual the day following our inspection visit. During our telephone meeting, we told the nominated individual about our immediate concerns. The nominated individual sent us evidence of some immediate actions they had taken to ensure the safety and wellbeing of people living at the home. We will continue to monitor any regulatory action as an outcome of this full inspection report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will act to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our findings below.

Is the service well-led?

Inadequate

The service was not well led

Details are in our findings below.

Holmfield Nursing Home

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection Team: One inspector, a specialist advisor and an expert by experience carried out this inspection. The specialist advisor had a nursing specialism. The expert by experience had personal experience of caring for older people.

Service and service type: Holmfield Nursing Home is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission (CQC). An existing nurse staff member has accepted promotion to the home manager role as from January 2019. The new manager was in the process of applying to become registered with CQC. A registered manager, as well as the owner and provider, are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced.

What we did when preparing for and carrying out this inspection:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We also sought feedback from the local authority and professionals who work with the service. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During our inspection we spoke with a nurse, the care team leader, four care staff, the cook, and housekeeper. We spoke with seven relatives and spent time with people to see how staff supported them.

On the day of our inspection visit, the new manager was on planned leave. Neither the provider nor the nominated individual (NI) were at the home that day. The NI made herself available to speak with us on the telephone. Like a provider, a Nominated Individual has legal responsibilities for supervising the management of the regulated activity, and ensuring the quality of the services provided.

We reviewed a range of records, including five people's care records and multiple medication records. We looked at records relating to the management of the home, including audits and systems for managing any complaints. We asked to look at the provider's visits to check on the quality of care provided, however, the NI told us these were informal and not recorded.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong:
• People who were at risk of, for example, falls or choking did not always have risk management plans to assess and inform staff how to reduce risks of harm.
• Where people had identified risks, information had not been used to create individual risk management plans to reduce identified risks of harm.
• The provider was responsible for analysis of accidents and incidents to identify patterns and trends and prevent a reoccurrence. Staff had reported and recorded accidents and incidents, but analysis to ensure risks of reoccurrence were mitigated, had not always happened.
• Some people had been identified as at risk of having or developing sore skin. Special equipment, such as airflow mattresses available, but the air flow pump settings were incorrect. People's plans of care did not contain the information staff needed to ensure settings were correct to the person's individual needs and checks were not undertaken. We discussed our concerns with the nominated individual during a telephone meeting the day after our inspection visit, who took action to address this.
• Some people had skin damage and nurses kept records to monitor healing or deterioration. Whilst, records reflected a level of monitoring took place, photographs were not consistently taken, or placed on people's care file, to closely monitor the changes.
• Personal Emergency Evacuation Plans (PEEPS) were not always in place. The fire safety file contained PEEPS for five people who were deceased and no PEEPs were in place for 11 people living at the home. One person's PEEP stated they could walk but staff told us the person could no longer walk. The missing and inaccurate information posed risks of delay and potential harm to people in the event of an emergency requiring people to be evacuated.
• Fire signage displayed directed staff to inform the fire service there were oxygen cylinders in use in the home. However, this was inaccurate, as oxygen cylinders had not been in use since September 2018.

Preventing and controlling infection:
• Some parts of the home were not well maintained which meant effective cleaning could not take place. For example, the dining room flooring was cracked, and seals were broken.
• Risks of cross infection were posed to people from bed rail bumpers that were damaged.
• Urinal bottles were rinsed and washed in people's en-suite sinks because there was no dedicated sluice facility.
• People who required transferring with a hoist did not always have their own allocated hoist sling which posed risks of cross infection.
• Overall, the home was clean and tidy.
• A Food Standards kitchen inspection had awarded the home a four-star rating during December 2018, which was an improvement from the previous three-stars awarded. The maximum star rating is five.

Using medicines safely:
• People's prescribed medicines were available. However, the management of medicines was not safe, and medicines were not always stored securely.
• At 10.30 am, on the day of our inspection, the nurse informed us they had administered everyone's morning medicines. However, one person's medicine administration record (MAR) had no signatures to confirm their 08.00 medicines had been given as prescribed, this included insulin. The nurse told us they had forgotten to administer this person's medicines and administered them at 11.00am. Giving this person's insulin three hours later than prescribed, and several hours after the person had eaten their breakfast, posed risks to their health and wellbeing.
• Seven people had prescriptions dated 17 December 2018 for oral care items following their dental visit. These prescribed items had not been obtained from the pharmacy and no action was taken to obtain the oral care items for people. When we pointed this out to staff during our visit, no action was taken.
• Staff did not follow pharmacy label instructions to safely store medicines following manufacturer's guidelines. One person's eye drops, dispensed on 4 January 2019, had been placed, unopened, in the medicine storage cupboard which had a recorded room temperature of 25 degrees. A pharmacy label on the eye drops stated they must be stored in a fridge between 2–8 degrees.
• On the day of our inspection the temperature of the medicine fridge showed 24 degrees, but should have showed a temperature range between 2-8 degrees. The nurse took no action to ensure the medicine fridge was operating correctly and people's medicines were stored safely and in line with manufacturer's instructions.
• We observed the nurse did not consistently follow safe practices. An open pot of prescribed 'thickener' powder was left on top of the trolley unattended for over an hour.
• One of the two medicine trolleys in use were not secured to the wall.
• People's personal information was not stored securely. MARs were stored on top of two medicine trolleys in a corridor, which was fully accessible to people, staff and visitors.

Systems and processes to safeguard people from the risk of abuse:
• Care staff had received training in how to safeguard people from the risk of abuse and demonstrated some understanding of safeguarding principles. However, the nurse in charge had not completed the provider's safeguarding training, nor been informed of the provider's safeguarding policy, which they were unable to locate.
• Relatives felt their family members were protected from the risks of abuse by staff working at the service.

The above concerns demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment:
• The provider did not have a safe system for recruiting staff and did not consistently ensure required checks were undertaken and / or recorded. The nurse in charge of the shift on the day of the inspection, had no employment file, and the day following our inspection visit, the nominated individual confirmed this could not be located. Of the five staff files looked at, four had missing information, which could not be found.
• There were insufficient staff on shift to meet people's individual needs. Staff told us they could safely meet people's physical needs but did not have time to offer emotional support and stimulation that people some people needed. However, one person told us they were in pain because they had slipped down the bed. When this person pressed their call bell to gain support from staff, it took them eight minutes to respond.
• During afternoon shifts, a care staff member undertook teatime meal preparation in the kitchen. This impacted staff's ability to maintain observations of the communal areas / respond so promptly to people's needs for assistance. One person had lifted their clothing in the lounge and staff were not on hand to assist this person to maintain their dignity. People cared for in their bedrooms often had to wait for staff to

respond to their request for support. Care staff's responsibilities included catering and laundry duties which took them away from their caring role.
• The provider currently used a 'physical needs based' assessment tool to determine staffing levels. However, this was not a person-centred tool, the nominated individual told us following guidance from the CCG and LA, they were planning to implement a nationally recognised tool to determine safe staffing levels based on people's individual holistic needs.

The above information meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations were not met.

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf, must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA applications procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Overall, care staff worked within the principles of the MCA and explained to people what was happening and gained their consent, for example, before repositioning them using a hoist.
• However, the provider had not ensured staff understood how to protect people's rights. One person, who had mental capacity to make decisions about their care, explained they had been told by a nurse they 'had to' have a bed rail on the side of their bed for 'their own good'. This person was in bed and we saw the bed rail was in place, they confirmed they "did not want it there". Alternative actions to reduce this person's risks of falls from bed had not been considered by staff or discussed with this person. The use of the bed rail restricted this person's liberty and the provider had no legal authorisation to do so.

The above concerns demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People had pre-admission assessments completed before they moved in. This included their medical history, mobility and nutritional needs. However, this information had not always been used to inform people's plans of care.
• Needs assessments were not always updated to reflect people's current needs.
• One person receiving a short stay at the home had no written plan of care.

Staff support: induction, training, skills and experience:
• Staff received training through self-guided workbooks. However, some staff told us they had not received an induction. The nurse on shift told us, "This is my second shift here as a bank nurse and I have not had an

induction, training or medicine competency assessment yet". During our inspection visit, the nurse worked a 12- hour shift without clinical support at the home or on-call clinical support.
• The provider's training matrix did not list the nurse or the new manager; who had worked as a nurse at the home since 2012.
• The provider had no record of nurse's clinical competency training undertaken or clinical skill assessments. Some nurses attended local hospital skills updates, but the training was not always effective because nurses had not ensured people's specialist mattresses had the correct setting based on their weight for optimal pressure relief.
• Care staff had opportunities to obtain nationally recognised vocational qualifications. Relatives felt staff had the skills they needed for their job role and, overall, we saw safe and effective moving and handling skills were used by staff.
• The provider's arrangements for staff training was not consistently effective. For example, we observed one person's feet dragged on the floor when they were transferred, by staff, using a wheelchair to support them from the lounge to the dining room. No foot-plates had been used to ensure the person's feet were protected from injury.
• The nominated individual told us staff had not received one to one meetings as planned, and staff meetings had not taken place as frequently as planned. The nominated individual assured us staff one to one meetings were planned to re-start from March 2019 and a staff team meeting had taken place during February 2019.

Supporting people to eat and drink enough with choice in a balanced diet:
• During our inspection visit, people were supported and offered sufficient to eat and drink, and told us they had adequate food at mealtimes. Drinks and snacks were offered between meals. However, one relative was concerned staff did not encourage their family member to drink enough to reduce risks of infection.
• Two people had been identified as potentially at risk of dehydration and malnutrition. Professional healthcare guidance had been sought for both people and prescribed food supplements were made available to them. Food and drink monitoring charts were kept by staff.
• Some people required their food to be pureed so it was soft enough for them to safely eat. However, food items had been pureed all together and presented in a bowl. This meant the person could not enjoy the separate flavours of the food. When we asked a staff member about the presentation, they told us, "That's how I was shown to do it." The care team leader told us this was not their expectation and food items should be pureed separately.
• Staff monitored people's weights and showed us records made available to the manager. Of the 15 people's recorded weights for January 2019, ten people had a recorded weight loss, that was not planned for. For example, two people had lost 3kg. No action had been taken to share people's weight loss information with staff preparing meals so additional calories could be added to people's food or high calorie snacks such as cheese could be offered to people between meals.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support:
• People had access to health care professionals and care staff gave us examples of when they would telephone for professional healthcare guidance.
• The provider had not ensured staff consistently followed healthcare professional's guidance. For example, prescriptions for oral hygiene items had not been obtained on their behalf.

Adapting service, design, decoration to meet people's needs:
• Some people's bedrooms, some communal areas and gardens required maintenance to improve tired-looking areas. Some bedroom furniture and furnishings supplied by the provider were worn and stained.
• For people living with dementia, no assessments had been carried out to assess what alterations and

adaptations, including suitable use of signage and decoration, were required.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect
Requires Improvement: People were not always well-supported, cared for or treated with dignity and respect. Regulations were met.

Ensuring people are well treated and supported:
• Positive interactions took place between people, care staff, the cook and the housekeeper. Those staff members consistently took opportunities to engage with people.
• People and their relatives described care staff as 'always kind' and 'very caring'.
• However, some staff did not demonstrate a caring approach. For example, some people called out 'nurse' to get the nurse's attention, but the nurse did not respond, or acknowledge, them.

Supporting people to express their views and be involved in making decisions about their care:
• Relatives told us staff had involved them in their family member's initial assessment to inform their plan of care. People had opportunities to share their life histories, their preferences and about things that were important to them.
• People had some opportunities to make independent choices. One person had ordered themselves a takeaway meal which they enjoyed. Another person indicated they were happy to remain in their bedroom and occupy their own time. Most people spent their time in the communal lounge but were unable to make choices about what they did and described 'everyday as the same', with the television being on. A few people expressed their frustration about one person being 'in charge' of the television remote control and they decided which programmes were on.
• People could not recall being invited to attend 'resident and relative' meetings and there were no recorded meeting minutes for 2018. The nominated individual told us meetings may have lapsed but they would ensure people and their relatives were made aware of one planned for March 2019.

Respecting and promoting people's privacy, dignity and independence:
• Staff respected people's privacy and we observed staff knocked on people's bedroom doors before entering.
• People's dignity was not always supported; there was a lack of maintenance and furnishings were worn. We discussed maintenance with the nominated individual and gave the dining room floor as an example of lack of timely maintenance. We had identified the need for the flooring to be replaced on a previous inspection during January 2016. The nominated individual told us the provider had hoped to replace the flooring in 2018 but it had not been done and no reason had been given for this.
• Staff showed discretion when asking people if they wished to use the toilet and maintained people's dignity.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met. Regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

• Most people had individual care plans and relatives told us they had been involved in discussing their family member's care. One person had short-stays at the home but had no plan of care or risk management plans to inform staff how to safely meet this person's needs.
• Nursing staff did not consistently respond to people's needs. One person told us they were in 'massive pain'. This person said they had already told the nurse but no one had taken any action to contact this person's GP. The day after our inspection visit, the nominated individual told us suitable pain relief had been obtained.
• Additional information about specific health conditions was inconsistent. One person's care plan contained detailed information which gave staff the additional information they required. However, another person's care plan contained no information about their health condition.
• A four-week plan of activities was displayed in the entrance of the home. However, planned activities were limited to three half days each week and these did not always take place because the designated activity staff member frequently undertook other roles.
• Care staff were constantly occupied in meeting people's physical needs or undertaking non-care tasks. Staff told us people often complained of being 'bored' and people made negative comments to us which included, 'there's nothing to do', 'every day is just the same with the television on' and 'it's very boring here'. The care team leader confirmed no activities were planned for the day of our inspection visit. They added when the activities staff member undertook their planned group sessions, people really enjoyed them. People confirmed this, but added 'things hardly ever happen though'.
• There was a lack of interaction and stimulation for people outside the delivery of care tasks and limited opportunities for people to engage with staff or each other. When staff supported people with tasks, they had a friendly approach, explained what was happening, and held conversations with people. Staff told us they would 'love' to be able to spend more time with people, talking and supporting them emotionally.
• Information was not available in an accessible format to people. For example, the provider's complaints policy was only available in a written format. The nominated individual was unware of the 'Accessible Information Standard' (AIS). The AIS aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support they need.

The above concerns demonstrated a breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulation 9. Person-centred care.

Improving care quality in response to complaints or concerns:
• There were no recorded complaints, to date, for 2019. However, prior to our inspection visit, a relative told

us they had made a written complaint to the provider, which had not been responded to. There was no record of this and the nominated individual was unaware of it.
• Most people and their relatives did not give examples of any complaints made or an indication they planned to make a complaint, and made positive comments about staff and the service. A few relatives gave us examples of when they had made verbal complaints to staff, such as about missing clothing or poor laundry services. However, there was no record of these, which meant opportunities may potentially have been missed to make required improvements and learn lessons.

End of life care and support:
• People had 'ReSPECT' assessments, where decisions had been made to 'Do Not Attempt Pulmonary Cardio Resuscitation' (DNACPR). These showed people or their relatives had been involved in making end of life care decisions.

Inadequate

Is the service well-led?

Our findings

Well Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. The provider and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

• At our inspection in March 2018, some improvements had been made to the provider's systems and processes to monitor the safety and quality of the service. However, further improvements were required and the improvements made needed to be embedded and sustained. The rating for this key question remained 'Requires Improvement'. This key question has been 'Requires Improvement' or 'Inadequate' since January 2016. At this inspection, improvements were still required. The provider's governance systems continued not to ensure high quality care. Previous improvements were either not sustained or not made in a timely way. The rating for this key question is now 'Inadequate'.

• During this inspection, some issues we had previously identified had not been improved on. For example, staff continued not have the information they needed to check people's specialist mattress settings were correct. On the day of our inspection visit, staff were unable to tell us what settings people's airflow pumps should be set on. Settings were inaccurate and checks were not made.
• The provider's governance systems to monitor the quality and safety of the service were inadequate and did not identify the shortfalls we found. We identified risks related to people's safety and welfare, an absence of risk management plans for some concerns we identified, incomplete and out of date personal emergency evacuation plans relating to fire safety, poor medicines management, risks of cross infection, and maintenance issues in the building, and insufficient numbers of skilled and knowledgeable staff, available to meet people's needs at all times had not been identified.
• Staff were not supported by the provider. On the day of our inspection visit, a nurse was working their second shift at the home and had no access to clinical on-call support. They had not received an induction, or any training from the provider since starting their employment.
• The provider did not ensure staff competency was assessed. The nominated individual told us observations of staff practices was something they needed to re-start to assure themselves safe and good care was provided.
• Care staff felt supported by their peers. The care team leader told us they lived close-by and would always come to offer support to care staff if needed. Staff felt supported through team meetings but one to one meetings had not taken place as planned. The nominated individual told us they hoped one to one meetings with staff would re-commence during March 2019.
• A quality monitoring visit from the Clinical Commissioning Group and Local Authority, on 4 January 2019, had identified improvements were required in systems of audit, including those for medicines and infection prevention and control. The provider's action plan recorded actions taken, some of which could not be evidenced to us during our inspection visit. The provider had listed actions for improvements, including a 'more in-depth medication audit' but there was no timescale for implementation.
• Employment files were not audited to ensure required checks had been undertaken and recorded.

• Staff failed to prioritise urgent maintenance issues. The nominated individual told us staff could telephone the maintenance staff member if anything required urgent attention. On the day of our inspection visit, one person's toilet was 'out of order' because it was blocked, and another person's toilet flush handle had broken. Whilst these issues were addressed the day after our inspection visit, the nominated individual told us they would have expected the nurse in charge to have requested the issues be attended to immediately.
• Safety and maintenance records did not evidence identified issues had been resolved. A gas safety inspection undertaken in January 2018 had noted the kitchen range had 'no interlock or safe systems of work in place' and an 'at risk warning notice' was issued. The nominated individual could not evidence the issue had been addressed. The provider informed us the issue had been addressed because their supplier of the kitchen range hood disagreed with the gas safety concerns raised. We requested evidence to demonstrate the 'at risk warning notice' has been addressed by a gas safety expert. However, the provider did not send this to us as requested.
• The system for auditing the premises and health and safety checks of the service was not effective. For example, uncovered radiators had not been identified as a potential risk and free standing wardrobes had not been identified as a potential risk of toppling over.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements:
• The owner / provider visited the service weekly. The nominated individual told us they visited and stayed at the service two or three days a week to provide managerial oversight. The nominated individual told us nurses had delegated responsibilities for ensuring people's day to day safety and care needs were met and regulatory requirements were met. In addition, the home manager had responsibilities for quality checks and oversight of risk management. However, nursing staff and the home manager had not always completed tasks relating to updating care records, risk management plans and quality assurance checks.

The above concerns demonstrated this is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014

• The Commission requires registered providers to report important information and incidents to us in a timely way. This had not happened. One person had sustained a serious injury and a statutory notification had not been sent to us. We discussed this with the nominated individual who submitted the notification to us at our request. The nominated individual told us they had not checked to ensure this notification had been sent to us as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• The nominated individual told us a quality assurance survey had been undertaken during 2018 but the information from this had 'gone missing'. A survey was planned for March 2019.
• The rating from the provider's last inspection was displayed, as required, in the entrance of the home.

Continuous learning and improving care:
• The nominated individual told us they worked with the local CCG when improvements were required and followed guidance given. Nurses attended workshops to update themselves on clinical skills but we found practices at the home did not consistently reflect skills and knowledge being implemented to ensure people received safe and effective quality care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not always receive person centred care that met their individual needs.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Need for Consent: The provider did not ensure the requirements of the Mental Capacity Act 2005 were consistently met.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment was not consistently provided in a safe way. Risks had not always been assessed and actions had not always been taken to mitigate risks. The provider had not ensured nursing staff had the competencies and skills required. Medicines were not consistently managed safely.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not effectively assess, monitor, and improve the quality or safety of the services provided. Risks were not always assessed, monitored or mitigated in relation to the health,

safety and welfare of service users.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive appropriate support to enable them to carry out duties they are employed to perform.

The enforcement action we took:

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